STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155038		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 08/26/	LETED	
	PROVIDER OR SUPPLIER		STREET A 2200 W	ADDRESS, CITY, STATE, ZIP C /HITE RIVER BOULEVA E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F0000	State Licensure Survey dates: A and 26, 2011 Facility number Provider number AIM number: 1 Survey team: Betty Retherfor Delinda Easter Ginger McNam Karen Lewis, R Census bed typ SNF/NF: 73 Total: 73 Census payor to Medicare: 10 Medicare: 10 Medicaid: 60 Other: 3 Total: 73 Stage 2 Sample These deficience findings cited in IAC 16.2.	August 22, 23, 24, 25, C 000013 er: 155038 00266100 d, RN-TC ly, RN ee, RN ee, RN ee:	F0000	F000 Preparation at execution of this plat correction does not admission or agreen provider of the truth alleged or conclusion the statement of defiplan of correction is and/or executed sole is required by the profederal and state law Nursing Center desired Correction to be of facility's Allegation of Compliance. Complied effective 9-26-2011.	n of constitute nent by the of the facts ns set forth in iciencies. The prepared ely because it ovision of v. Parkview res this Plan considered the if iance is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BLS311

Facility ID:

000013

TITLE

l 1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLE	ETED	
		155038	B. WING	-	08/26/20	011	
		1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEI	₹		/HITE RIVER BOULEVARD			
PARKVII	EW NURSING CEN	TER		E, IN47303			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT				
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG	 	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	31, 2011 by Be	ev Faulkner, RN					
F0242 SS=D	schedules, and he or her interests, a care; interact with both inside and or choices about aspfacility that are signed based on recount the facility faile received fresh each shift as the residents interwater in a Stage (Resident #'s 8 Findings included #88 was review p.m. Resident #88's included, but we Parkinson's, ald disorder, hyperisident with the stage of the	,	F0242	Resident #88, 76 and 40 a Resident Council will be interviewed to determine it need ice water passed mo frequently than once every and will be provided ice wa indicated per their choice a frequency. Staff were in serviced on 9/8/2011 to ensure the pro of ice water is passed eve and as per resident reques Residents will be interview for compliance of ice wate passed each shift and the Resident Council will be as its regular monthly meeting special meetings are held water pass is being provid each shift and as requeste desired if more frequent of ice water is needed. Any	they re rshift ater as and rvision ry shift sts. red daily r being sked at g and if if ice ed ed or fer of	09/26/2011	
		vas identified as on a list, which was		concerns that the Residen Council addresses will be on a Resident Concern Fo provided to the Administra	written rm and		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED	
		155038	B. WIN			08/26/20	011	
		1	P. ,, 11,		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF	PROVIDER OR SUPPLIEI	₹			HITE RIVER BOULEVARD			
PARKVII	EW NURSING CEN	TER			E, IN47303			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{т=}	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	provided by the	e Administrator on			remedy, action or resolution	will		
	8/22/11 at 12 r	ioon.			be addressed and the next	.		
					regularly scheduled Residen	t		
	During an inter	view with Resident #88			Council meeting. This will be monitored by the	.		
	_	2:06 p.m., he indicated			administrator or designee. A			
		eive fresh ice water			recommendations will be	,		
		oom on a daily basis.			reviewed by the QA Committ	ee to		
	l ·	e had to ask for ice			ensure any concerns from th			
	water if he war				Resident Council are addres	sed		
	water if the War	ileu II.			to include the procedure of passing ice water at its regul	orly		
	O \ D	atamiaith Daaidant			scheduled monthly meeting	, i		
		nterview with Resident			needed for compliance.) as		
		ent Council President,			Unit managers will			
		:00 p.m., he indicated			complete rounds to ens	ure		
		eive fresh ice water in			Ice water has been			
		daily basis. He			provided every shift dail	, l		
		ad to ask for ice water if			times two weeks, three	,		
		He indicated he knew			times a week for four			
		e to pass ice water			weeks, then one time a			
		lay but they did not. He			week for two months			
	further indicate	ed the water in his room			and monthly thereafter.			
	had been sittin	g there for a few days.			•			
					DON/or designee will	,		
	3.) During an ii	nterview with Resident			complete rounds weekly For three months to ens			
	#76 on 8/24/11	at 10:00 a.m., she				ure		
	indicated she	did not get ice water 3			ice water has been			
	times a day. S	she indicated she had			Provided every shift.			
	1	r if she wanted it. She			Identified trends will be	.		
	also indicated	sometimes she would			reviewed in QAA month	· 1		
	have to go get the water herself. Resident #76 was on an interviewable list provided by the Administrator on 8/22/11 at 12 noon.				For 3 months and quart	erly		
					thereafter to determine			
					further education and/or			
					further monitoring needs	s.		
					Identified non-compliand	ce		
	4) Review of t	he monthly resident			will result in one to one			
	1 '	s indicated on the			re-education up to and			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155038	A. BUI	LDING	00	COMPL 08/26/2	
		100000	B. WIN			00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PARK\/IF	EW NURSING CENT	TER		1	'HITE RIVER BOULEVARD E, IN47303		
					L, 11477000		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		residents complained		_	including termination. A	nv	
		ving ice water passed			identified trends will be		
	in their room,	g ioo iiato. paoooa			forwarded to the		
	,				administrator		
	1/7/11, resident	ts complained about			for review and presente	d to	
		nging ice water,			QAA to determine furth		
		have to ask for water.			educational needs.		
	 				Completion Date of 9-26-20	11.	
	4/19/11, reside	nts indicated they have					
	to ask for ice w	ater, staff do not pass					
	to rooms daily						
	Review of the c	current facility policy,					
	dated April 201	0, titled "Hydration					
	Status", provide	ed by the RN					
	Consultant on 8	3/26/11 at 1:30 p.m.					
	indicated the fo	llowing,					
		lealth Services, In.					
	` ′	o reduce the risk of					
		by identifying risk,					
		ilizing, and reversing					
	1	d promoting resident					
	care practices t	to improve hydration					
	7 Implementin	odividuolizod					
	7. Implement in	ased on resident needs					
		sidering the resident's					
		ardian's choice and					
	, ,	nich promote fluid					
	l '	ain sufficient hydration					
		which may include,					
		ted to the following,					
		to the following,					
	a. Assure a cor	ntainer of water is					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		155038	B. WING	ino		08/26/2	011
				STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			HITE RIVER BOULEVARD		
PARKVIE	W NURSING CEN	TER			E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	1	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE
	unless contrain	ent's reach at all times, dicated					
	c. Provide fluid be managed by independently"						
	During an inter of Nursing on 8 she indicated the expected to paragraphic and the state of the s						
	resident's room	ns on every shift.					
	3.1-3(u)(1)						
F0244 SS=E	facility must listen the grievances and residents and fam policy and operation resident care and	or family group exists, the to the views and act upon d recommendations of ilies concerning proposed onal decisions affecting life in the facility.	F024	14	Residents #76, 10, 40, 88 an	d 48	09/26/2011
	the facility failed council grievant a timely manned concerns for 5 reviewed for for availability of ice	lled to ensure resident ances were acted upon in ner to prevent continued 5 of 19 residents food quality and ice water in a Stage 2 5. (Resident #'s 76, 10,			had voiced a concern at the Resident Council about cold food. These residents will be interviewed to determine their choice of the food temperature and also the passing of ice wand to determine their need frimprovement on the food temperatures and passing ice water. Staff was in-serviced on 9/8/2/	r res ater or	
	Findings include: 1.) Review of the resident council minutes from January 2011 through				to ensure the provision of pro- food temperatures and ice wa is passed every shift and as president requests.	ater per	
		andary 2011 unough			Residents will be interviewed	ually	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DITT	DDIC	00	COMPL	ETED
		155038	A. BUII B. WIN			08/26/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	NAME OF PROVIDER OR SUPPLIER						
		TED			HITE RIVER BOULEVARD		
PARKVII	EW NURSING CEN	IER		MONCI	E, IN47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	August 2011, t	he following food			for compliance of food		
	related concer	ns were noted:			temperatures and ice water	'	
					being passed each shift.		
	January 7, 201	1: "Food usually cold."			Resident Council will be as its regular monthly meeting		
	1	ce water, have to ask			temperatures and ice water		
	for it."	oc water, have to dok			is being provided each shift		
	101 11.				as requested or desired. Ar		
		44. 110			concerns that the Resident		
	1	11: "Breakfast on hall			Council addresses will be w	ritten	
		ner is cold, and			on a Resident Concern Forr	n and	
	weekends (foo	d) is cold." The			provided to the Administrato		
	minutes of the	meeting lacked any			Remedy, action or resolution	n will	
	information and	d/or response related to			be addressed at the next		
	1	mplaint of cold food.			regularly scheduled Resider	nt	
	1	cked any response to			Council meeting. This will be monitored by the	_	
	1	of ice water not being			administrator or designee.		
	•	_			recommendations will be	W I y	
	1 '	d indicate it was being			reviewed by the QA Commit	tee to	
	passed at that	time.			ensure any concerns from the		
					Resident Council are addres	ssed	
	1	: "No discussion of old			to include the procedure of		
	minutes." The	March minutes lacked			passing ice water at its regu		
	any information	n and/or response			scheduled monthly meeting	or as	
	related to the F	ebruary complaints of			needed for compliance.		
	cold food.	, ,			Unit managers will		
					complete rounds to ens	ure	
	April 19 2011.	"No discussion of old			Ice water has been		
	1 '	als not always hot."			provided every shift dai	ly	
	1	•			times two weeks, three		
	1	ater. Keep telling them			times a week for four		
	1 7	n." A Resident Council			weeks, then one time a		
	Report, dated 4/20/11, and signed by the Administrator on 4/29/11, indicated the dietary department had been provided training on food preferences and food temperatures.				week for		
					two months and monthl	v	
					thereafter.	J	
					DON/or designee will		
					•		
	1 -	ked any information			complete rounds weekl	-	
		vater concerns.			For three months to en	sure	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SU	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		155038	B. WIN			08/26/20	11
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			1	HITE RIVER BOULEVARD		
D/\ DK\/ [EW NURSING CEN	TED		1	E, IN47303		
	-W NORSING CEN	TER		MONCH	L, IIV47 303		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	<u> </u>	DATE
					ice water has been		
	June 20, 2011:	"Food is okay, but			Provided every shift.		
	always cold."				Dietary manager will		
					monitor temperature and	d	
	No minutes we	ere provided for a July			Palatable of hall and dir	ning	
	meeting. The	meeting on 8/11/11			room trays		
	1	ormation related to a			daily times two weeks, t	hen	
	response to the	e 6/4/11 meeting.			three times a week		
					for four weeks and then		
	, ,	interview with Resident			weekly. Adminitrator		
	#40, the Resid	ent Council President,			will follow up with dietar	y	
	(identified as "i	nterviewable" by the			temperature logs weekly	y	
	facility) on 8/25	5/11 at 1:00 p.m., he			to ensure proper		
	indicated				temperatures are being		
	residents have	told him the food is			observed.		
	sometimes col	d. He indicated they			Identified trends will be		
	were supposed	d to get ice water three			reviewed in QAA month	ly	
	times a day bu	t he frequently has to			For 3 months and quart	erly	
	get ice water h	imself. He indicated			thereafter to determine		
	the water in his	s room had been sitting			further education and/or	.	
	there for a day	or so. He indicated the			further monitoring needs	s.	
	1	always respond to their			Identified non-compliand		
		don't know if they			will result in one to one		
	forget or what.	•			re-education up to and		
	•	problems still occur			including termination. A	ny	
		inues to be concerns			identified trends will be	´	
		food and ice water.			forwarded to the		
					administrator		
	3.) The clinica	I record for Resident			for review and presente	_{d to}	
	1 '	ved on 8/24/11 at 2:30			QAA to determine further		
	p.m.				educational needs.		
					Completion Date of 9-26-20	11.	
	A quarterly Mir	nimum Data Set (MDS)			•		
		ated 6/10/11, indicated					
	•	nad no problems with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155038	A. BUII B. WIN			08/26/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		l	HITE RIVER BOULEVARD		
D/ DK//IE	EW NURSING CEN	TEB			E, IN47303		
FARRVIE	W NORSING CEN	TER		WONCH	E, 11147303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	his ability to un	derstand others.					
	During an inter	view with Resident #10					
	•	20 a.m., information					
		regarding facility					
		d service. Resident					
		ne ate his meals in his					
		cated there were still					
	l ·	cold food and the food					
	was not always	s hot.					
	4.) The clinica	I record for Resident					
	#76 was reviev	ved on 8/24/11 at 10					
	a.m.						
	Resident #76 v	vas identified as					
	interviewable c						
	"Interviewable c	•					
	•	view on 8/23/11 at					
	'	sident #76 indicated					
		d to be problems with					
	the food being	cold. She indicated					
	she eats her m	eals in her room. She					
	indicated the fo	ood was cold at times,					
	"almost every	·					
	1	rater was not always					
		as supposed to be and					
	l •						
	sile irequently	had to go get it herself.					
	[_ ,	0/00///					
	, ,	interview on, 8/23/11 at					
	•	sident #48 (identified					
	as interviewabl	le on the Interviewable					
	list), indicated	he ate meals in his					
	room. He indic	cated the food was					
		ne time he got it.					

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 08/26/2	ETED	
	PROVIDER OR SUPPLIER		ST 22	200 WI	DDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 6.) During an in 12:05 p.m., Reas interviewable list), indicated to	nterview on 8/22/11 at sident #88 (identified e on the Interviewable hey did not always get ndicated "You have to	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Administrator of p.m., additional requested related to the concerns council meeting only response padministrator response page page page page page page page pag	elated to cold food and s was the one dated					
	10:50 a.m., the indicated there in the facility strong 2010 and so protocols had rindicated he had to provide relations.	were lots of changes aff around November me of the facility not been followed. He ad no other information ed to the facility's e resident council					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
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			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HITE RIVER BOULEVARD		
PARKVIE	W NURSING CENT	ΓER			E, IN47303		
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TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0248 SS=D		rovide for an ongoing es designed to meet, in					
00-5	accordance with the						
	assessment, the ir	nterests and the physical,					
	mental, and psych resident.	osocial well-being of each					
İ	Based on obse	rvations, record	F0	248	Resident #44's care plan was	s	09/26/2011
		erviews, the facility			reviewed and the care plan for	or	
		the activity program			this resident was updated to		
		ctivity needs for 1 of 3			include activity preferences a		
		wed for activities in a			level of participation. Resider		
					#44's Activity Progress notes were updated to include a		
	Stage 2 Sample	e of 35 (Resident #44).			summary of her activity		
					preferences and participation		
	Findings includ	e:			level. An Activity Assessmer		
		16 5 11 1 111			was completed and the resul	ts	
		ord for Resident #44			were then care planned.		
	was reviewed o	on 8/24/11 at 9:45 a.m.			All resident Activity Care Plan were reviewed to ensure the	ns	
	Current diagnos	ses for Resident #44			Activity Assessments provide		
		ere not limited to,			the residents needs and the		
	•	on, dementia, right			plan reflected these needs. A care plans that were determined		
	•	ondary to brain injury.			to need updated to reflect the		
	ricinipicgia scc	oridary to brain injury.			assessment was completed.		
	During chaory	tion on the following			Residents will be reviewed by	y the	
	_	tion on the following			IDT team weekdays at DCR,	at	
		Resident #44 was			time of initial/annual assessn		
	-	her wheelchair in her			and quarterly assessment for	ſ	
		ny type of activity			needed updates to ensure		
	occurring,				systemic changes are effecting and any changes of resident		
					conditions are addressed in t		
	8/22/11, at 10:3	30 a.m., 1:45 p.m. and			care plan to reflect activity		
	3:20 p.m.				needs.		
	8/23/11, at 9:00	a.m., 11:00 a.m. and			This will be monitored by the		
	4:00 p.m.				administrator or designee. A	ny	
	•				recommendations will be		
	An admission N	/linimum Data Set			reviewed by the QA committee		
		ated 1/1/11 indicated			monthly to ensure changes to activity programming to meet		
	Assessinent, U	ateu 1/1/11 iliultateu			activity programming to meet		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	
		155038	B. WING			08/26/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
TWIND OF I	NO VIDER OR SOLVER		I .		HITE RIVER BOULEVARD		
Parkvie	EW NURSING CENT	ΓER		MUNCIE	E, IN47303		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	during a reside				assessed care plan needs of	the	
		ed the following			residents. Activity Director will conduct		
		important to her,			documented audit of		
	listening to mus	sic, doing things with a			Residents activity needs weekly	,	
	group of people	e, doing her favorite			times 4 weeks and then		
	activities, going	outside when the			as appropriate using the MDS		
	weather is good	d and participating in			schedule thereafter. Audits		
	religious praction	ces.			will be submitted monthly for 3		
					months and quarterly thereafter at the center QA meetings. Iden		
	A Quarterly Mir	nimum Data Set			trends will be	unica	
	Assessment, da	ated 7/20/11 indicated			addressed as deemed appropriat	e by	
	Resident #44 re	equired extensive			the QA Committee	J	
	assistance from	n the staff with all			through 1:1 re-education and the	e	
	activities of dail	ly living.			appropriate disciplinary		
					process per policy.		
	Review of a hea	althcare plan, dated			Completion Date of 9-26-201	1.	
		ed the resident did not					
	have any limita						
		goal for the activity					
	_	s plan of care was, will					
		pendently and with					
	•	participate in activities					
		es per week, will					
		oup activities listed as					
	l · · · ·	cise, interventions					
	•	activities as preferred					
	· ·	kercise, country music,					
		-					
		ual activities, wheeling					
		king, watching TV,					
		ers and family, outings,					
		nterests, provide					
		ar for resident, provide					
		transportation and					
	provide in room	supplies for leisure.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL		
		155038	B. WIN			08/26/2	011
	PROVIDER OR SUPPLIER		. · ·	2200 W	ADDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	note on the clin 2/11/11. The note of the clin 2/11/11. The note resident had attemptograms on available and the clinical appropriate of the clinical and the c	articipation summary - lired leisure activities g , resident					
	of Nursing on 8 she was asked activity director facility did not control activity director activity attenda Resident #44 for August. Review of the aby the Director at 2:30 p.m., incompared to the second s	activity record provided of Nursing on 8/24/11 dicated the following, vity attendance record lent #44 attended 5					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2011
	PROVIDER OR SUPPLIER		2200 W	ADDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	,	ity record indicated the ed 7 activities for the			
	through 8/23/12 had attended 5 resident was no	11 activity record I indicated the resident 5 activities. The ot listed as having ctivities on 8/22/11 and			
	p.m., he indicat	view with the n 8/24/11 at 12:30 led the previous rs last day in the facility			
	he indicated the additional information related to Residual participated in a than the times	n 8/26/11 at 3:45 p.m., e facility had no mation to provide dent #44 having any activities other			
	3.1-33(a)				
F0253 SS=E	maintenance servi a sanitary, orderly Based on obse	rovide housekeeping and ices necessary to maintain , and comfortable interior. rvation and interview, d to ensure resident	F0253	The East Side Shower Roon Rooms 205, 206, 210, 216, 2	07/20/2011

l '		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155038	B. WIN	G		08/26/2	011
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF I	ROVIDER OR SOLITEIE			2200 W	HITE RIVER BOULEVARD		
PARKVII	EW NURSING CEN	TER		MUNCIE	E, IN47303		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·		DATE
		wer rooms were			308, 310 and 114 were place maintenance work orders an		
	1 ' ' '	ained and in good			repairs for each room were	u lile	
	· •	34 resident rooms			completed. Room 205 the		
	observed (Roo	m numbers 205, 206,			bathroom floor was cleaned	by	
	210, 216, 220,	308, 310, and 114),			housekeeping to remove the		
	and 1 of 2 show	wer rooms currently in			black spots, Room 210 the n	netal	
		ts residing on the East			door frame to the bathroom		
	Hall (East Hall shower). This affected				gouge was repaired and the		
	15 residents who resided in 8 of 34				frame painted. Room 220 th		
	rooms observed and potentially				caulk missing around the sto was repaired and flooring	101	
	affected 73 residents who used the				repaired. Room 308 the cau	lkina	
					around the stool was repaire		
	East Hall show	er.			and the water leak stopped f		
		_			the stool. Room 206 the cau	ılking	
	Findings includ	le:			around the stool was repaire		
					Room 310 the dent in the do		
	During the env	ironmental tour with the			was repaired. The closet do		
	Maintenance D	irector and the			rooms 216, 114, 220, 210 ar 210 were placed back on the		
	Administrator of	on 8/26/11 at 9:30 a.m.,			tracks and the floor tracking		
	the following co	oncerns were identified,			the closet doors was put in p		
		,			The East Hall shower room		
	a The bathroo	m floor in Room 205			cracked and broken ceramic		
		ed areas of substance			flooring was repaired and the		
		4 inches by 4 inches in			cove base has been replace		
	1	vere black, dark brown			All resident bathrooms and re		
		,			have been inspected for nee repairs and those repairs have		
	in color. At the				been scheduled for completi		
		e Administrator wet a			Staff were in serviced on		
	1	d the substances on			9-8-2011 to ensure the		
	the bathroom f	loor were removed.			completion of work orders when	hen	
					there are maintenance or bro	oken	
	b. The metal de	oor frame to the			items that need repair are	.	
	bathroom in Ro	oom 210 was gouged			properly reported so they can	n be	
	and paint was	• •			scheduled for repair. Rounds for repairs will be		
	' ' '	3			completed by the Administra	tor	
	c The bathroo	m in Room 220 had			with the maintenance director		
		ılk missing from around			weekly to ensure the residen		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155038	B. WIN	IG		08/26/201	11
NAME OF	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
DA DI G (II				1	HITE RIVER BOULEVARD		
PARKVII	EW NURSING CEN	IER		MUNCI	E, IN47303		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ΓE (COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	the stool, the caulk that was in place				rooms are in good repair. Ar recommendations will be ma		
	was discolored and brown in color.				the QA committee at its regu		
					scheduled meeting monthly t	· .	
		m in Room 308 had			ensure resident care areas a	re in	
	1	ılk missing from around			good repair.		
		er was observed on the			Maintenance supervisor	will	
	floor next to the stool.				complete rounds	.	
					daily times two weeks, t	hen	
	e. The bathroom in Room 206 had				three times a week		
	caulk around the stool that was brown				for four weeks and then		
	and discolored.				weekly thereafter to		
					ensure resident rooms a	and	
	f. The bathroom door in Room 310				shower rooms are		
	had a dent in the	ne wooden door			properly maintained and	l in	
	approximately	the size of a baseball.			good repair.		
					Adminitrator will comple	te	
	1 -	oors in Resident			room		
		14, 220, 310 and 210			checks weekly for three	s	
	were off the tra	icks and were			months. Identified		
	nonfunctional.				trends will be reviewed i	in	
					QAA monthly		
		all shower had a section			x 3 months and quarterl	у	
		pproximately 2 feet in			thereafter to		
	0	from the floor and the			determine further educa	tion	
	1	exposed. The shower			and/or further		
	room had 5 see	ctions of ceramic tiles			monitoring needs. Ident	ified	
	missing from th	ne floor.			non-compliance		
					will result in one to one		
	During an inter				re-education up to		
	Maintenance D	Director at the time of			and including terminatio	n.	
	the environmer	ntal tour, he indicated			Any identified		
	the above cond	cerns needed to be			trends will be presented		
	repaired.				and reviewed		
					during QAA to determine	e	
	3.1-19(f)				further educational		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	, DIC	00	COMPL	ETED
		155038	B. WING	ING		08/26/2	011
				STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HITE RIVER BOULEVARD		
PARKVIE	W NURSING CENT	ΓER	MUNCIE, IN47303				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					needs.		
					Completion Date 9-26-2011.		
E0270	A facility must use	the regulte of the					
F0279	A facility must use	velop, review and revise the					
SS=D		nensive plan of care.					
		Tollow plan or care.					
	The facility must d	evelop a comprehensive					
	care plan for each	resident that includes					
		tives and timetables to meet					
	a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	The care plan mus	st describe the services that					
	•	d to attain or maintain the					
	resident's highest	practicable physical,					
		osocial well-being as					
		83.25; and any services that					
		e required under §483.25					
	•	ed due to the resident's					
		under §483.10, including the					
	_	tment under §483.10(b)(4).	E02	70	The care plans for residents	#1	00/26/2011
		d review, observation,	F02	/9	10 and 49 were updated.	<i>IT</i> 1,	09/26/2011
		he facility failed to			Resident #49 care plan was		
	•	rehensive health care			updated to include refusal of	care	
		oped for 3 of 28			and treatment, Resident #10	care	
	residents reviev				plan was updated to include		
	comprehensive	health care plan			seizure disorder and Resider		
	development in	a Stage 2 sample of			care plan was updated to inc	lude	
	35. (Resident #	's 1, 10, and 49.)			post cataract removal and treatments and medications	for	
					this condition.	OI .	
	Findings includ	e:			All care plans were reviewed	and	
	. 5				updated as necessary.		
	1.) The clinical	record for Resident			IDT will review all new orders	and	
	,	ed on 8/24/11 at 2:45			diagnosis and include on the		
	p.m.				residents care plan. This pro		
	γ				will be completed from the 24		
					hour report and reviewed in t	.ne	l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155038 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 WHITE RIVER BOULEVARD PARKVIEW NURSING CENTER MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Diagnoses for Resident #49 included, daily clinical review and proceed to care plan. but were not limited to, pressure This will be monitored by the ulcers, diabetes mellitus, DON or designee and reviewed hypertension, and congestive heart by QA committee will review at failure. least monthly residents with new diagnosis and medication changes to ensure they are The nursing notes indicated the included on the residents plan of resident refused treatment including, but not limited to, going to wound DON/or designee will care center appointments, plans for any needed turning/repositioning, and foot wound updates care. 11 times in the time frame of daily clinical review. 6/22/11 to 8/20/11. Unit Managers will review care plans for necessary The clinical record lacked any updates comprehensive health care plan with all new orders daily (HCP) having been developed related times two weeks, then three to Resident #49 refusing care. times a week for four weeks and During an interview with the Director then weekly for two months of Nursing (DoN) on 8/25/11 at 12:25 and then monthly. Identified p.m., additional information was trends will be reviewed in requested related to the lack of any QAA monthly comprehensive HCP having been x 3 months and quarterly developed regarding the resident's thereafter to refusal of care/treatment. determine further education and/or further During an interview with the Director monitoring needs. Identified of Social Services (DSS) on 8/25/11 non-compliance at 2:20 p.m., she indicated the Mood will result in one to one and Behavior Symptom re-education up to Assessment/Plan of Care, dated and including termination. 7/27/11, included, but was not limited Any identified to: trends will be presented

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	155038	- 1	LDING	00	08/26/2	
		10000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00,20,2	
NAME OF F	PROVIDER OR SUPPLIER				HITE RIVER BOULEVARD		
PARKVIE	EW NURSING CENT	ΓER		1	E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		xpresses desire to die	+	mo	and reviewed		DATE
		will accomplish this by			during QAA tio detiermine furtihe	r	
	no longer eating or going to doctor appointments Goal: Resident to intake appropriate				educational needs.		
					Completion Date 9-26-2011		
	nutrition and se professionals.	ek advise of medical					
	Interventions:	Family notified and to					
	speak with resident. Food to be						
	offered and pos						
	regarding G-tub						
		Psych consult (in cheduled. 15 minute					
	,	ours due to suicidal					
	ideations.	ours due to suicidai					
		mood and behavior					
		plan had no additional					
	_	als and interventions to					
		sident's refusal of The care plan had no					
		ited interventions to					
	•	lent's possible G-tube					
		consult, and 15 minute					
		suicidal ideations.					
	The facility faile	ed to provide any					
		mation as of exit on					
	8/26/11.						
	,	record for Resident					
		ed on 8/24/11 at 2:30					
	p.m.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155038	B. WIN			08/26/20	011
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE (HITE RIVER BOULEVARD)		
	EW NURSING CEN	ΓER		1	E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		Resident #10 included,		1/10			DATE
	_	nited to, acute hypoxic					
	respiratory failure secondary to cerebral vascular accident, seizure disorder, and renal insufficiency.						
		ord indicated Resident					
	•	henytoin sodium (an					
		medication) 300 e daily related to his					
	_	seizure disorder.					
	diagnosis of a s	scizure disorder.					
	Seizure disorde	er was listed on the fall					
	prevention hea	lth care plan as an					
	added fall risk,	but it did not identify					
	the need for me	edications to prevent					
	seizures and/o	• -					
	_	ded related to the					
	diagnosis and r	medication use.					
	The clinical rec	ord lacked any					
		health care plan					
	•	eveloped related to his					
	•	seizure disorder					
	requiring the ne						
		medication and					
	possible monito	oring.					
	During on inter	viow with the					
	During an inter	nd Director of nursing					
		2:15 p.m., additional					
		s requested related to					
		omprehensive health					
		g been developed for					
	-	diagnosis of a seizure					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED '2011
	PROVIDER OR SUPPLIEF		2200 W	ADDRESS, CITY, STATE, ZIP (/HITE RIVER BOULEV E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	disorder.					
		ed to provide any mation as of exit on				
	l '	record for Resident #1 on 8/24/11 at 10:30				
	_	Resident #1 included, ited to, status post al.				
	10:00 a.m., LP eye drop medic The eye drop a Prednisolone A anti-inflammato drops one drop	ory eye drop) 1% eye to the left eye. The eye was noted to be				
	comprehensive having been de resident having	ord lacked any health care plan eveloped related to the had cataract surgery or eye drops to be				
	p.m., the Cons was unable to	view on 8/26/11 at 2:30 ultant RN indicated she provide any health care plan				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038		(X2) MULTIPL A. BUILDING B. WING	E CON	00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC DESITE YEAR OF DEFORMATIONS	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	related to the recataract surger drops four time 4.) Review of the policy, dated 1/2 Care," provided 8/26/11, at 1:30 was not limited "POLICY A Plan of Care documentationPROCEDUR 2. Complete including the form	he current facility '08, titled "Plan of d by the DoN on o p.m., included, but to, the following: is part of the process E the Plan of Care by llowing:	TAG		DEFICIENCY)		DATE

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155038	A. BUILDING	00	08/26/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/20 11
NAME OF P	PROVIDER OR SUPPLIER		I	/HITE RIVER BOULEVARD	
	W NURSING CENT		MUNCI	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG	policy, dated 2/	· · · · · · · · · · · · · · · · · · ·	IAG		DAIL
	•	ily Conference,"			
		e DoN on 8/26/11, at			
		ided, but was not			
	limited to, the following:				
	"Procedure				
	7. Seek optio	ons with the help of the			
	•	cian, resident or legal			
	representative if the resident or legal				
	representative refuse a prescribed				
	treatment.				
		sing and other			
		efforts to identify other			
	_	alternative methods of			
	_	problem(s) if the			
	_	al representative refuse			
	a prescribed tre	eatment"			
	3.1-35(a)				
	3.1-33(a)				

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIMI DING	00	COMPLETED	
		155038	A. BUILDING B. WING		08/26/2011	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		/HITE RIVER BOULEVARD		
PARKVII	EW NURSING CEN	TER	MUNCIE, IN47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	 	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0280 SS=D	incompetent or of incapacitated und participate in plan changes in care at a comprehensive developed within of the comprehen by an interdiscipli attending physicia responsibility for tappropriate staff i by the resident's in practicable, the pather resident's famore representative; are revised by a team each assessment Based on recompetent interview, the famore health care plan updated for 1 of Stage 2 sample #45). Findings included the review was conducted for 1 of Stage 2 sample #45). The resident #1 review was conducted for 1 of Stage 2 sample #45). The resident #2 review was conducted for 1 of Stage 2 sample #45).	care plan must be 7 days after the completion sive assessment; prepared nary team, that includes the an, a registered nurse with he resident, and other n disciplines as determined needs, and, to the extent articipation of the resident, illy or the resident's legal nd periodically reviewed and of qualified persons after rd review, and facility failed to ensure ans were reviewed and of 28 residents in a e of 35. (Resident de: 45's clinical record mpleted on 8/25/11 at health care plan for a short stay plan of care	F0280	Resident #48 care plan was updated immediately. All care plans were audited to determine the need for any updates. All care plans will be audited monthly to ensure the care pare up to date by the Interdisciplinary Team. This will be monitored by the DON or designee and review by the QA committee monthl any discrepancies in the plan care and updates. DON/or designee will caplans for any neede updates daily clinical review. Unit Managers will review care plans for necessar updates	to d plans e wed ly for n of are	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDDIC	00	COMPL	COMPLETED	
		155038		LDING	-	08/26/2	011	
		1	B. WIN					
NAME OF I	PROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP CODE			
				1	HITE RIVER BOULEVARD			
PARKVII	EW NURSING CEN	IER		MUNCI	E, IN47303			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	problem goals	were dated 6/11.	I		with all new orders daily	,		
					times two weeks, then the	hree		
	During an inter	view with the Director			times			
	of Nursing and Administrator on				a week for four weeks a	nd		
		25 p.m., additional			then weekly for two mor			
		s requested related to			and then monthly. Ident			
		ent health care plan			trends will be reviewed i			
	reviews for Res				QAA monthly	"		
	I LEVIEWS IOI KE	3146111 #4J.			•	,		
	District of the form	ndammidh tha Diaratas			x 3 months and quarterl	у		
	During an interview with the Director of Nursing on 8/25/11 at 2:30 p.m.,				thereafter to			
					determine further educa	ition		
	she indicated the health care plan for				and/or further			
	Resident #45 h	nad not been updated			monitoring needs. Ident	ified		
	until 8/25/11.				non-compliance			
					will result in one to one			
	2.) Review of	the current facility			re-education up to			
	policy, dated 1.	/08, titled "Plan of			and including terminatio	n l		
		d by the DoN on			Any identified	···		
	· •	0 p.m., included, but			trends will be presented			
		I to, the following:			and reviewed			
	Was not immited	ite, the fellowing.				_		
	"POLICY				during QAA tio detiermine furtiher educational needs.			
	1 02.01				Completion Date 9-26-2011			
	A Plan of Care	is part of the			23p.0			
		-						
	documentation	process						
		_						
	PROCEDUR	E						
		the Plan of Care by						
	including the fo	ollowing:						
	c. Identifi	ed need						
	d. Realist	tic, measurable						
	resident goal	,						
	· · · · · · · · · · · · · · · · · · ·		- 1					

i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 08/26/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0282 SS=D	f. Specific interventions in columnh. Signatu 3.1-35(d)(2)(B) The services providacility must be provided in the services and services provided in the services pro	ed date the goal will c individualized the "Intervention" ure and date" ded or arranged by the ovided by qualified persons a each resident's written					
	and interview, to ensure the nurs transcribed and orders to ensur medication was 20 residents remedication adm 2 Sample of 35 103) Findings including the nurse of the nurse transcribed and	being given for 2 of viewed for correct ninistration in a Stage . (Resident #'s 1 and	F0282	Residents #1 and 103 physicorders were reviewed immediately to ensure no clarifications were needed a any corrections were made. All physicians' orders were reviewed to ensure that no corders for any resident needed be clarified. All Nurses will be in-serviced include the clarification of physician orders and transcof physician order accuracy. This will be monitored by the DON or designee at DCR. Recommendations will be be to the QA committee for reviewed.	nd other led to d to ription		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155038 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 WHITE RIVER BOULEVARD PARKVIEW NURSING CENTER MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 10:00 a.m., LPN #4 administered an least monthly to ensure clarifications are completed and eye drop medication to Resident #1. transcription of orders are The eye drop administered was accurate. Prednisolone AC 1% eve drops one Unit managers will review drop to the left eye. all new physician orders for needed The clinical record for Resident #1 clarification and appropriate was reviewed on 8/24/11 at 10:30 transcription to MAR/TAR a.m. The clinical record for Resident daily times two #1 lacked any order for the weeks, three times a week Prednisolone 1% eye drop for four medication. The eye drop order was weeks, then one time a for Prednisolone AC 0.125% 1 drop to week for the left eye four times daily. The two months and monthly original date of this order was 7/6/11. thereafter. Identified trends will be During an interview with the LPN #4 reviewed and Unit Manager #5 on 8/24/11 at in QAA monthly x 3 months 10:40 a.m., additional information was and requested related to the lack of an quarterly thereafter to order for the Prednisolone AC 1% eye determine drop medication given to Resident #1. further education and/or further During an interview on 8/24/11 at 1:50 monitoring needs. Identified p.m., Unit Manager #5 indicated she non-compliance will result had talked to the pharmacy regarding the eye drop order. She indicated the one to one re-education up pharmacy told her they had sent out an "Urgent-need to clarify" notice and including termination. related to the 7/6/11 eye drop order Any shortly after it was received indicating identified trends will be there was no 0.125 solution of forwarded Prednisolone eye drops and the order to the administrator for was written in error. Unit Manager #5 review and indicated she had no knowledge of

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPI	
AND PLAN OF CORRECTION		155038	- 1	LDING	00	08/26/2	
		100000	B. WIN		ADDRESS OF VICTOR OF THE CORE	00/20/2	.011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE /HITE RIVER BOULEVARD		
PARKVIE	PARKVIEW NURSING CENTER			1	E, IN47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed to clarify" request			presentied tio QAA tio detiermin	е	
		ceived and the order			furtiher educational needs Completion Date 9-26-2011		
		larified and changed at			Completion Date 3-20-2011		
		indicated the physician					
		contacted and the					
	1%.	to Prednisolone AC					
	1 /0.						
	This indicated a	a time period of over					
	50 days that the	e nursing staff had					
	administered th	e Prednisolone 1%					
		ation to Resident #1					
	when both the i	medication					
	administration r						
	physician's ord						
		C 0.125 % was to be					
	given.	100le elipiaal vaaavd					
	l '	103's clinical record					
		on 8/24/11 at 1:15 p.m. as admitted to the					
		11. The resident's					
	1	ided, but were not					
	_	rtension and a hepatic					
	mass.	-r					
		ad hydrochlorothiazide					
	-	hypertensive] on his					
		rs. The order was					
		ifferent areas on the					
		d each order was					
	different. One						
	1	izide 25 mg, give one					
	1	eryday and the second the resident was to					
	Lieceive one 30	mg tablet orally					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 12011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			2200 W	ADDRESS, CITY, STATE, ZIP CO /HITE RIVER BOULEVA E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	orders were sig	resident's current gned by the physician contained the order bys.				
	2011, indicated hydrochlorothia	Record for August, I the resident received azide one tablet of 25 00 a.m., and 50 mg				
	Unit Manager f 8/24/11 at 1:35 the hydrochlord have been clar was admitted to indicated she w	view with RN #5, the or Resident #103, on p.m., she indicated othiazide order should ified when the resident of the facility. She would contact the ve the order clarified.				
	8/25/11. The on hydrochlorothic should be given	azide was obtained on rder indicated the azide 50 mg only n daily and a Basic le blood test should be				

AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPL A. BUILDING B. WING	00		(X3) DATE S COMPL 08/26/20	ETED
PARKVIEW NURSING CENTER (XO ID. SUMMARY STATEMENT OF DEFICIENCIES			220		ss, city, state, zip code RIVER BOULEVARD 7303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CRO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infectinormal bladder fur Based on recort the facility failed resident review (urinary) cathet of 35 had physisize of the cath of the urinary Fused. [Resident #21's reviewed on 8/The resident had physician order The physician order the physician order the physician order the changed months in the physician's order physician's order the physician's order the changed months in the changed months in the physician's order	d review and interview, d to ensure 1 of 1 ed with a Foley er in a Stage 2 Sample cian's orders for the eter and the bulb size oley catheter to be at #21] e: clinical record was (24/11 at 2:00 p.m. ad signed, but undated, as for August, 2011. Orders indicated the ry Foley catheter was a c bladder and was to onthly. There were no ers for the size of the and the size the	F0315	wei fold imminct for any was need for oth have catt Nun ens and corres Thi DO rec rev leas the ord rev	sident #21 physician's order clarified and an order for catheter was obtained mediately. The orders did lude size and type of catheter yer esident who has a catheter sassessed to determine the deformant of catheter and type of catheter. The er residents were found to be a need for clarification of the er orders. The er orders were in-serviced to sure the proper transcription or the proper transcription or the er order for catheters will be monitored by the end of the er orders. The er will be monitored by the end of the er orders will be monitored by the end of the er orders will be involved by the QA committed the er orders with catheters to end it is a monthly for any orders idents with catheters to end it is a monthly for any orders idents with catheters to end it is a monthly for any orders idents with catheters to end it is a monthly for any orders idents with catheters to end it is a monthly for any orders idents with catheters to end it is a monthly for any orders idents with catheters to end it is and type is written in the end in t	eter. eter the orders No or of on ee rrent s. eee at of nsure of the orders the the order the orders the orde	09/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155038 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 WHITE RIVER BOULEVARD PARKVIEW NURSING CENTER MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Review of the Nurse's Notes indicated of catheter And bulb size of foley catheter to be used during daily the following: clinical review. Unit Managers will 5/22/11, 10:00 a.m., Catheter complete audits to ensure changed with return of 400 cc's of Residents with catherters have amber urine. physician orders for Size of catherter and bulb size of foley 5/23/11, 5:00 p.m., Resident returned catherter to be Used while for doctor's appointment at this time reviewing trancscriptions to with no new orders. MAR/TAR daily times two weeks, 5/24/11, 5:45 a.m., Resident's Foley then three times a week for four catheter drainage bag emptied of 175 weeks and then weekly for two months and then monthly. cc's of dark red urine. The medical Identified trends will be reviewed doctor was notified on 5/23/11, when in QAA monthly the catheter was changed and the x 3 months and quarterly resident had complained of pain. The thereafter to resident had no complaint of pain at determine further education this time. and/or further 5/26/11, 1:00 a.m., The resident monitoring needs. Identified continues on an antibiotic for a UTI non-compliance [urinary tract infection.] will result in one to one 5/27/11, 5:00 a.m., Antibiotic re-education up to continues for UTI. and including termination. 5/27/11, 3:15 p.m., The resident's Any identified catheter changed #14 French. Amber trends will be presented urine returned. The resident tolerated and reviewed it well. during QAA tio detiermine furtiher 5/27/11, 11:30 p.m., Antibiotic educational needs. continues for UTI without adverse Completion Date 9-26-2011 effects. Urine light amber, acrid odor with white sediment. 5/28/11, 10:30 p.m., The resident continued on an antibiotic for UTI. 5/29/11, 6:00 a.m., Late entry for 5/28/11, 6:00 a.m. to 2:00 p.m., continues on an antibiotic for UTI and his urine remained foul.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CC A. BUILDING B. WING	00	lì í	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET A 2200 W	ADDRESS, CITY, STATE, ZIP O HITE RIVER BOULEV E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	medical doctor antibiotic] 100 is seven days for 5/29/11, 9:30 p continues on an his urine has a temperature is 5/31/11 through dark amber with antibiotic contine 6/3/11 through continued on a 6/18/11, 5:00 p stated his cather French with a 3 was put in. 7/2/11, 8:00 a.r. A #18 French in amber yellow ut 7/8/11, 12:00 p changed this mander yellow ut 7/8/11. Anchor frequently. Me and it is ok to a urologist. 7/13/11, 6:00 p returned from the orders. 7/19/11, 2:00 p catheter came Foley catheter was inserted.	.m., The resident n antibiotic for UTI and foul smell. His 100.0 degrees. n 6/2/11, The urine was h a foul odor and the nued for a UTI. 6/4/11, The resident n antibiotic for a UTIm., The resident eter fell out. A new 22 80 cc balloon catheter m., Catheter changed. nserted with 300 cc				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 7/2011		
	NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	catheter with a with a return of	leg bag was inserted yellow urine.						
	5/23/11, indicated complained of pand the catheter indicated the result indicated the result indicated the result indicated the result indicated though a "Physician Note 5/24/11, indicated complained of phad blood in his indicated she will blood was from catheter or if the urine analysis."	otification" form, dated the resident pain from his catheter er was just changed. It esident had been on antibiotic] two times a I to 5/11/11. The nt he had another UTI. otification" form, dated the resident pain with urination and is catheter. The nurse was not sure if the intrauma caused by the e resident needed a						
	5/30/11, indicat large amount o drainage from t The resident was Macrodantin 10	red the resident had a f yellowish, thick the penis and catheter. as receiving 00 mg, two times a day and had a temperature						
	p.m., with the F Manager for Re indicated she d	view on 8/22/11 at 2:47 RN #5, the Unit esident #21, she lid not know why the d a catheter. She						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155038	B. WING		08/26/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			VHITE RIVER BOULEVARD		
PARKVIEW NURSING CENTER		MUNC	IE, IN47303			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, i	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE	
		esident was admitted				
	with a catheter	on 3/25/11.				
	5	5:				
	_	view with the Director				
	_	3/25/11 at 3:20 p.m.,				
		he resident did not				
		for the size of catheter				
	the resident wa	is to have.				
	0.4.44(.)(0)					
	3.1-41(a)(2)					
F0323		ensure that the resident				
SS=E		ins as free of accident				
		sible; and each resident				
	devices to prevent	e supervision and assistance				
	· ·	rvation and interview,	F0323	Rooms 310, 231 and 232 rooms	oms 09/26/2011	
		d to ensure it was free	1 0323	were immediately repaired for	0 > 7 = 07 = 0 1 1	
	•	and/or fire hazards for 6		electric baseboard heaters fi		
		occupied 3 of 34 rooms		covers. They were placed o		
		g the Stage 1 resident		heaters properly and secure All other rooms were audited		
		•		any other resident rooms an	I	
	-	i. (Room #'s 310, 231,		common areas that needed		
	and 232)			to the baseboard heaters we	•	
		1		slated for repair. The		
	Findings includ	e.		Maintenance Director then w to each room identified from	• • • • • • • • • • • • • • • • • • •	
	1) During on a	observation of Room#		audit and completed the repa		
	,			each baseboard heater and		
		at 9:30 a.m., the metal		secured the front covers. St	aff	
		oorboard heater		were provided in-serviced or		
		windows had a half		9-8-2011 to ensure the report		
		nad slipped down and		any unsafe condition to inclu missing baseboard heater co	•	
	was not coverir			and to fill out a work order a	I	
	elements. This	s exposed a section of		report the het cover for imme		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/26/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			2200 W	ADDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	approximately	netal heating coils 3 feet long. This room by two residents.		repair. Housekeeping will monitor of unsafe conditions daily on the daily cleaning schedule and report needs order forms are turning them in to maintenath Weekly rounds will be made the Administrator and maintenance man to ensure repair of baseboard heaters. Any unsafe condition found reported to the Maintenance Director for immediate repair This will be monitored by the administrator or designee. recommendations will be reviewed by the QA commit work orders needed ensure safe environment for reside areas. Maintenance supervisor complete rounds daily times two weeks, three times a week for four weeks and there weekly thereafter to ensure metal covers are properly placed over heaters. Adminitrator we complete room checks weekly for three months. Identified trends will be reviewed QAA monthly x 3 months and quarter thereafter to determine further eductionand/or further	heir I I I I I I I I I I I I I I I I I I I

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/26/2011			
	NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
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	2. During an o 231 on 8/23/11 electric wall bo window was m the heating coi occupied by tw 3. During an o on 8/23/11 at 9 wall board hear was missing the heating coils. occupied by tw 4. During an ir on 8/23/11 at 9 the electric wall and the setting low to high by the each resider 5.) During an ir on 8/23/11 at 9 the electric wall and the setting low to high by the each resider	bservation of Room at 9:28 a.m., the ard heater under the issing the cover over ls. This room was o residents. bservation of room 232 :32 a.m., the electric ter under the window e cover over the This room was o residents. atterview with CNA #6 :34 a.m., she indicated I board heaters work s can be adjusted from the thermostats located		monitoring needs. Ider non-compliance will result in one to one re-education up to and including terminati Any identified trends will be presente and reviewed during QAA to determine further educational needs. Completion Date 9-26-2011	on. d ne			

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2011
	PROVIDER OR SUPPLIER		STREET A 2200 W	ADDRESS, CITY, STATE, ZIP CODE (HITE RIVER BOULEVARD E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	related to the e elements in Ro	oms 310, 231, and 232 The Administrator ould have the aff address the			
F0329 SS=E	from unnecessary drug is any drug w (including duplicat duration; or withou without adequate if the presence of according to the dose seems of the dose seem	ug regimen must be free drugs. An unnecessary when used in excessive dose e therapy); or for excessive at adequate monitoring; or indications for its use; or in dverse consequences which should be reduced or my combinations of the			
	resident, the facilit residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unle	rehensive assessment of a sy must ensure that e not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and e clinical record; and antipsychotic drugs receive ctions, and behavioral iss clinically contraindicated, continue these drugs.			
	Based on recor the facility failed residents review medications has support the use	rd review and interview, d to ensure 3 of 10 wed for unnecessary d a diagnosis to e of the medication 1, 44, and 88] and	F0329	Residents #21, 44, and 88 to pressure was assessed and review of their medications completed. Resident #27 working reviewed for unnecessary medications. A review of all residents'	l a was

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155038	A. BUILDING		08/26/2011
		100000	B. WING		
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE	
				VHITE RIVER BOULEVARD	
PARKVIE	EW NURSING CEN	TER	MUNC	IE, IN47303	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	failed to monito	or the blood pressure		medications was completed	
	for 1 of 10 residents [Resident #27] reviewed for unnecessary			determine if any resident ha	· I
				unnecessary medications.	
	medications in a Stage 2 Sample of			residents were reviewed for	plood
	35.			pressure monitoring and documentation in their clinic	
	33.			record.	ai
				Nurses were in-serviced on	the
	Findings includ	e:		need to properly document I	I
				Glucose and Blood Pressure	.
	1. Resident #2	21's clinical record was		monitoring in the clinical rec	ord
	reviewed on 8	/24/11 at 2:00 p.m.		and recording in the correct	
	The resident's	diagnoses included,		location. Nurses were also	
	but were not lin	nited to, dementia with		in-serviced on the use of	
	behavioral dist			unnecessary drugs.	DOM
	hypertension.	andanioss, and		This will be reviewed by the	DON
	i riyperterision.			or designee. Any recommendations will be	
				reviewed by the QA committ	ee at
		ad signed, but undated		least monthly to ensure the	cc at
		rs for August, 2011.		monitoring systems for	
	The physician	orders indicated the		documentation of blood glud	ose
	resident was re	eceiving finasteride [for		monitoring and blood pressu	.
	benign prostati	c hypertrophy] give one		monitoring are in place and	
	5 mg tablet dai	ly. The original date of		changed as needed.	
	. •	3/25/11. Review of the		DON/or designee will	
		lacked a supporting		review all new physicial	n
				Orders to ensure	
	diagnosis for th	ie use of the		appropriate diagnosis to	
	medication.			support	
				Use of medications duri	ina
		2:35 p.m., The Director		daily clinical review.	'' ⁹
	of Nursing prov	vided a 7/13/11, form		1 -	
	with the diagnosis of History of BPH [benign prostatic hypertrophy.] She indicated the form was not in the			Unit Managers will	
				complete audits to ensu	ire
				All medications have	
resident's chart. She indicated she had just called the physician and had the form faxed to the facility.			appropriate supporting		
				Diagnosis daily times to	vo
			weeks, then three times	;	
	i ile ioiiii iaxeu	to the facility.		a week for four weeks a	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038			(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 08/26/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303	ı
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	#88 was review p.m. Resident #88's listed on the clir Parkinson's, tre seizure disorde anxiety and department with the control of the contro			then weekly for two monand then monthly. Identified will be reviewed QAA monthly x 3 months and quarter thereafter to determine further educational needs. Identified trends will result in one to one re-education up to and including terminational including terminational needs. Completion Date 9-26-2011	tified in ly ation tified

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 08/26/2	ETED	
		100000	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF F	PROVIDER OR SUPPLIER				HITE RIVER BOULEVARD		
PARKVIE	EW NURSING CEN	ΓER		MUNCI	E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		acked any diagnosis					
	related to why t	the resident was					
	receiving the narcotic pain						
	medication.						
	During an interview with the Director						
		/25/11 at 3:30 p.m.,					
		mation was requested					
		gnosis for the use of					
	the routine narcotic pain medication.						
	During an interview with the Director						
		3/26/11 at 3:00 p.m.,					
		ne facility did not have					
		the clinical record to					
	''	e of the routine pain Resident #88. She					
		d the facility would call					
		nd verify the indication					
	for use of the m	nedication.					
	3) The clinical	record for Resident					
	'	red on 8/24/11 at 9:45					
	a.m.						
		6 D 11					
	_	ses for Resident #44					
	· ·	ere not limited to, on, dementia, and right					
		ondary to brain injury.					
	Resident #44 h	ad a current					
		er for the Docusate					
	Sodium (a stoo						
	•	nely at 8 a.m. and 8					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 00	li i	E SURVEY PLETED
		155038	A. BUILDING B. WING		- 08/26/	2011
	PROVIDER OR SUPPLIER		2200	ET ADDRESS, CITY, STATE, ZIP CO WHITE RIVER BOULEVA ICIE, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	p.m.					
	The clinical rec diagnosis related was receiving the medication on a During an interport of Nursing on 8 additional information related to a diagnosis on related to the unsoftener medicated the fallowing and the medicated the fallowing of the medic	ed to why the resident he stool softener a routine basis. view with the Director /25/11 at 3:00 p.m., mation was requested gnosis to support the ication. view with the Director /26/11 at 3:00 p.m., he facility did not have the clinical record se of the routine stool ation. She further cility would call the verify the indication for ication. record for Resident ved on 8/24/11 at 1:31 Resident #27 included, hited to, lementia with				
	osteoarthritis, h diabetes mellitu A signed recap	ypothyroidism, and us. itulation of physician's				
	orders, dated 8	/18/11, indicated				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155038	B. WIN			08/26/2011	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		2200 W	HITE RIVER BOULEVARD		
	EW NURSING CEN	TER			E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
		ad an order for a					
		ressure check. The					
	original date of this order was						
		ent #27 had a current					
		er for Norvasc (a blood					
	l •	cation) 5 milligrams 1					
	, ,	Resident #27 had a					
	current physicia						
		ochlorothiazide (a blood					
	•	cation) 20-25 milligrams					
	1 table everyda	ıy.					
		Administration					
		ne and July were					
		out of 9 opportunities,					
		sure readings were not					
	documented.						
		view with the Director					
	•	view with the Director					
	l • ,	N) on 8/25/11 at 3:45					
	•	l information was					
	·	ed to the lack of blood					
	l ⁻	oring on 6/8/11,					
	6/15/11, 7/21/1 ⁻	i and //18/11.					
	During an inter	view on 8/26/11 at					
	•	RN Consultant					
	1	id not have any					
		mation to provide					
		ack of blood pressure					
		6/8/11, 6/15/11, 7/21/11					
	and 7/18/11.	JOI 11, 0/10/11, 1/2 1/11					
	and //10/11.						
	3.1-48(a)(3)						
	3.1-48(a)(4)						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155038	B. WING			08/26/2	011
			D. WIIW		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HITE RIVER BOULEVARD		
PARKVIF	W NURSING CENT	TER			E, IN47303		
			_				(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG			DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)		IAG			DAIL
F0332 SS=D	medication error ragreater. Based on obse record review, the ensure a medication and resulted in a medication admiresulted in a medication admiresulted in a medication sto. [Resident of the resident of the medications to 8/24/11 at 10:41 to give the resident of the medications o	ving medications. 3 ation were observed rtunities for error in ninistration. This edication error rate of this 15 and 13] e: s observed passing Resident #15 on 0 a.m. The LPN failed dent Thera-Plus quid 5 ml's and oride [a mineral omEq [milli-equivalent] indicated at the time s were not available. clinical record was 24/11 at 10:45 a.m. 8/18/11, signed	F0	332	Residents #15 and 13 were assessed for any potential adverse reactions from the medication error. The physic and family were notified. The nurse was immediately disciplined for the medication error. LPN #2, RN #3 were counseled. Monitoring of medication pas provided by the UM daily to ensure the residents are received the proper medication. In-service training has been provided to the nurses on propass medication procedure. This will be monitored by the DON or designee. Any recommendations will be broat to the QA committee to ensure med pass procedures are in place. Education Training Direct will complete medication administration observation with all licensed nurses with any needed follow the education. DON/or designee will complete medication.	es is seiving oper ought re ctor nons	09/26/2011
		s included, but were Thera-Plus liquid give 5			administration	£1	
		mara i lao liquiu givo o			observations once a shi	IL	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155038	B. WIN			08/26/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HITE RIVER BOULEVARD		
PARK\/IF	EW NURSING CEN	TER		1	E, IN47303		
					L, 114-7-000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	"	gastronomy tube] once			weekly for two		
	a day, and potassium chloride 25				months and then weekly	/ for	
	mEq tablet give	e one tablet dissolved			one month and then as		
	via g-tube once	e a day.			needed		
					for any identified trends.		
	2. RN #3 was	observed passing			Identified		
	medications to Resident #13 on				trends will be reviewed i	n	
		p.m. The RN gave			QAA monthly		
					x 3 months and quarterl	V	
	Resident #13 a calcium 500 mg with 200 IU [international units] of vitamin				thereafter to	y	
	D [a vitamin and mineral supplement]				determine further educa	tion	
					and/or further	lion	
	tablet orally.					· C' I	
					monitoring needs. Identi	itiea	
		clinical record was			non-compliance		
		/24/11 at 3:45 p.m.			will result in one to one		
	The resident's	current physician's			re-education up to		
	orders were sig	gned on 7/21/11. The			and including terminatio	n.	
	orders included	d, but were not limited			Any identified		
	to, calcium 500	mg with vitamin D 200			trends will be presented		
	IU give one tab	olet orally three times a			and reviewed		
	_	. The resident was not			during QAA tio detiermine furtihe		
		with the medication			educational needs.		
	•	g meal was scheduled			Completion Date 9-26-2011		
		etween 5:00 p.m. and					
		etween 5.00 p.m. and					
	5:30 p.m.						
	The	00					
		08, revised Procedure					
		Administration was					
	· •	e RN Consultant on					
		p.m. The procedure					
	indicated the lie	censed nurse and/or					
	medication assistant will check for the						
	right time wher	n passing medication.					
		. •					
	These findings	resulted in a					
	i iliaaa iiliailiga						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2011
	PROVIDER OR SUPPLIER		2200 W	ADDRESS, CITY, STATE, ZIP CODE /HITE RIVER BOULEVARD E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	medication erro	or rate of 6 percent.			
F0333 SS=D		nsure that residents are ant medication errors.			
	Based on record the facility failed orders were cladifferent orders pressure medication getting instead of one. residents review medication error of 35. Resider	d review and interview, d to ensure medication drified related to two for a diuretic blood dration resulting in the d two doses daily This affected 1 of 10 dwed for significant fors in a Stage 2 sample and # 103	F0333	Resident #103 was assessed any potential adverse reactifrom the medication error. In physician and family were notified. The nurse was immediately disciplined for the medication error. Monitoring of medication paragraphs provided by the Unit Manag daily to ensure the residents receiving the proper medical In-service training has been provided to the nurses to teat them the proper way to passed medication and to eliminate errors in passing medication. This will be monitored by the DON or designee. Any	he ss is er s are tion. ach s

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155038 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 WHITE RIVER BOULEVARD PARKVIEW NURSING CENTER MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE reviewed on 8/24/11 at 1:15 p.m. The recommendations will be brought to the QA committee to ensure resident was admitted to the facility med pass procedures are in on 8/4/11. The resident's diagnoses included, but were not limited to. DON/or designee will hypertension and a hepatic mass. review all new physician Orders are transcribed The resident had two different properly to MAR/TAR physician's orders for during daily clinical review. hydrochlorothiazide [a diuretic-Unit Managers will antihypertensive] on his admission complete audits to ensure orders. One order indicated All physician orders have hydrochlorothiazide 25 mg, give one been transcribed tablet orally everyday and the second appropriately order indicated the resident was to To MAR/TAR daily times receive one 50 mg tablet orally two weeks, then three times everyday. The resident's current a week for four weeks and orders were signed by the physician then weekly for two months on 8/11/11. and then monthly. Identified trends will be reviewed in Review of the Medication QAA monthly Administration Record for August, x 3 months and quarterly 2011, indicated the resident received thereafter to hydrochlorothiazide one tablet of 25 determine further education mg daily at 10:00 a.m., and 50 mg and/or further daily at 3:00 p.m. from August 5, 2011 monitoring needs. Identified through August 23, 2011. non-compliance will result in one to one During an interview with RN #5, the re-education up to Unit Manager for Resident #103, on and including termination. 8/24/11 at 1:35 p.m. She indicated Any identified the hydrochlorothiazide order should trends will be presented have been clarified when the resident and reviewed was admitted to the facility. She during QAA tio detiermine furtiher indicated she would contact the educational needs. physician to have the order clarified. Date 9-26-2011

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/26/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	8/25/11. The o hydrochlorothia should be given	izide was obtained on rder indicated the izide 50 mg only n daily and a Basic le blood test should be					
F0364 SS=E	provides food prep conserve nutritive appearance; and f attractive, and at t Based on recor the facility failed served to the r at a hot, palata of 19 residents quality in a Stag	nood that is palatable, the proper temperature. It review and interview, to to ensure meals the esidents were served to ble temperature for 4 the reviewed for food to ge 2 Sample of 35. to 10, 40, and 48)	F0364	Residents #76, 10, 40, and 4 had voiced a concern at the Resident Council about cold food. They will be interviewed determine their choice of the temperatures and also the passing of ice water and to determine their need for improvement on the food temperatures and passing ic water. Staff were in-serviced on	ed to food		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BLS311

Facility ID:

000013

If continuation sheet

Page 46 of 58

li '		(X2) M				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155038	B. WIN	IG		08/26/2	U11
NAME OF I	PROVIDER OR SUPPLIER	}		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	HITE RIVER BOULEVARD		
PARKVII	EW NURSING CEN	TER		MUNCIE	E, IN47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ne resident council			9/8/2011 to ensure the provis of proper food temperatures		
	minutes from January 2011 through				ice water is passed every shi		
	1 -	he following food			and as per resident requests		
	related conceri	ns were noted:			Foods will be monitored and		
					temperatures taken daily on	all	
	January 7, 201	1: "Food usually cold."			meals.		
	February 3, 20	11: "Breakfast on hall			Residents will be interviewed	i daily	
	still cold."				for compliance of food temperatures and ice water		
	April 19, 2011:	"Meals not always			being passed each shift and	the	
	hot." June 20, 2011: "Food is okay, but always cold."				Resident Council will be aske	ed at	
					its regular monthly meetings		
					food temperatures and ice w		
					pass is being provided each and as requested or desired.		
	During an inter	view with Resident			concerns that the Resident	Ally	
		ent Council President,			Council addresses will be wr	itten	
		nterviewable" by the			on a Resident Concern Form	and	
	l '	5/11 at 1:00 p.m., he			provided to the Administrator		
	indicated	рин, не			Remedy, action or resolution be addressed and the next	Will	
		told him the food is			regularly scheduled Residen	.	
		d. He indicated council			Council meeting.	`	
		not always fully acted			This will be monitored by the		
	•	nes the problems still			administrator or designee. A	ny	
		e continues to be			recommendations will be		
		ed to cold food.			reviewed by the QA Committ ensure any concerns are	ee to	
		54 to 6614 1664.			addressed from the Resident	t l	
	2 The clinical	record for Resident #10			Council to include Food		
		on 8/24/11 at 2:30 p.m.			Temperatures and the proceed	dure	
	was reviewed (311 0/2 4 /11 at 2.30 p.m.			of passing ice water at its		
	Δ quarterly Min	nimum Data Set			regularly scheduled monthly needed for compliance.	oras	
		ated 6/10/11, indicated			Dietary manager will		
	· ·	nad no problems with			monitor temperature and	,	
		•			Palatable of hall and din		
	his ability to understand others.				room trays	'''9	
	During on inter	viou with Docidont #10			daily times two weeks, t	han	
	-	view with Resident #10			three times a week	11611	
	on 8/23/11 at 9	:20 a.m., information			unee unes a week		

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/26/2	LETED
PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303	1	
SUMMARY S (EACH DEFICIENT REGULATORY OR Was requested meals and food #10 indicated he room. He indic problems with was not always 3. The clinical #76 was review a.m. Resident #76 winterviewable of "Interviewable of "Interviewable of "Interviewable of "Interviewable of "Interviewable of "Interviewable of "Interviewable" During an interviewable of "Interviewable" Dur	TER TATEMENT OF DEFICIENCIES (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) regarding facility d service. Resident he ate his meals in his cated there were still cold food and the food s hot. record for Resident wed on 8/24/11 at 10 vas identified as on the facility list. view on 8/23/11 at sident #76 indicated d to be problems with cold. She indicated eals in her room. She bod was cold at times, day." Interview on, 8/23/11 at sident #48 (identified e on the Interviewable	B. WIN	STREET A	HITE RIVER BOULEVARD	I TE Ty Ty Ty Ty Tified Tified The tified	(X5) COMPLETION DATE
room. He indic often cold by th	ne ate meals in his cated the food was ne time he got it. He ad talked to the Dietary the cold food.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155038 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 WHITE RIVER BOULEVARD PARKVIEW NURSING CENTER MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The drug regimen of each resident must be F0428 reviewed at least once a month by a licensed SS=D pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted Residents #21, 44 and 88 were Based on record review and interview. F0428 09/26/2011 reviewed for unnecessary the Consultant Pharmacist failed to medications without a supporting identify 3 of 10 residents reviewed for diagnosis. Diagnosis were unnecessary medications in a Stage 2 located in the clinical record and sample of 35 for the use of identified on the chart, pharmacy was notified to include on the medications without a supporting rewrites each month. diagnosis. [Resident #'s 21, 44, and All residents' charts were 881 reviewed to identify any resident who had a diagnosis that was not Findings include: listed in the clinical record and corrections were made immediately. 1). Resident #21's clinical record was Clinical review will occur daily at reviewed on 8/24/11 at 2:00 p.m. DCR for changes needed in the The resident's diagnoses included, clinical record. Monthly reviews of but were not limited to, dementia with the resident's clinical records will be completed by the DON. behavioral disturbances, and This will be monitored by the hypertension. DON or designee. Any recommendations will be The resident had signed, but undated reviewed by the QA committee to ensure any changes needed to physician orders for August, 2011. the clinical record followed. The physician orders indicated the Consultant Pharmacist will resident was receiving finasteride [for review resident medications benign prostatic hypertrophy] give one Monthly for any 5 mg tablet daily. The original date of unnecessary medications the order was 3/25/11. Review of the and make medical record lacked a supporting Recommendations as diagnosis for the use of the necessary. medication.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 08/26/2	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITE RIVER BOULEVARD MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated the rewere reviewed Pharmacist on pharmacy recordinical record id did not have a On 8/26/11 at 2 of Nursing proviet the diagnoral benign prostate indicated the foresident's charmacist of the resident's charmac	211, physician's orders esident's medications by the Consultant 8/4/11. There was no mmendation on the ndicating finasteride supporting diagnosis. 2:35 p.m., The Director yided a 7/13/11, form esis of History of BPH ic hypertrophy.] She form was not in the t. She indicated she the physician and had to the facility.			DON/or designee will review all new consultary pharmacist Recommendations with physician and obtain or as needed. Identified trends will be reviewed in QAA monthy x 3 months and quartery thereafter to determine further educational needs. Identified trends will result in one to one re-education up to and including terminational including terminational including terminational including QAA tio detiermine furtible educational needs. Completion date 9-26-2011	ders ally ly ation tified	
	•	record for Resident ved on 8/24/11 at 2:30					
	listed on the cli Parkinson's, tre	current diagnoses nical record were, emors, alcohol abuse, er, hypertension, pression.					
	Resident #88 h physician's ord	ad a current er for Oxycodone (a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL				
		155038	B. WING			08/26/2	011		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
 PARKVIE	PARKVIEW NURSING CENTER			2200 WHITE RIVER BOULEVARD MUNCIE, IN47303					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	•		(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL] 1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE		
	•	edication) 7.5/325							
	. •	blets, every 4 hours to d routinely at 10 a.m.,							
		and 10 p.m. The							
	l '	the order was 6/4/11.							
	The clinical rec	-							
	-	ed to why the resident he narcotic pain							
	medication.	ne narcone pain							
		ord indicated the							
	1	acy Consultant had							
		lent #88's record on							
	report lacked a	armacy Consultant's							
	•	pport the use of the							
	•	pain medication.							
		view with the Director							
	•	1/25/11 at 3:30 p.m.							
		mation was requested gnosis for the use of							
		cotic pain medication.							
		1							
		view with the Director							
	"	3/26/11 at 3:00 p.m.							
		ne facility did not have the clinical record to							
	ı •	e of the routine pain							
		Resident #88. She							
	further indicate	d the facility would call							
		nd verify the indication							
	for use of the m	nedication.							

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTI 00	ON	(X3) DATE S COMPL 08/26/2	ETED
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STRE 220		ZITY, STATE, ZIP CODE ZER BOULEVARD	!	
			STRE 220	O WHITE RIN	/ER BOULEVARD	NTE .	(X5) COMPLETION DATE
	reviewed Residence record on 6/6/1 Pharmacy Contains any indication of support the use softener medical During an interferon of Nursing on 8 additional information.	view with the Director 6/25/11 at 3:00 p.m., mation was requested gnosis to support the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIDTEM	or conduction	155038	A. BUILDING		08/26/2011	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			HITE RIVER BOULEVARD		
PARKVIE	EW NURSING CENT	TER	MUNCI	E, IN47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE COMPLETION DATE	
	During an interview with the Director of Nursing on 8/26/11 at 3:00 p.m., she indicated the facility did not have a diagnosis on the clinical record related to the use of the routine stool softener medication. She further indicated the facility would call the physician and verify the indication for use of the medication. 3.1-25(h)					
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screes tate; and progress Based on record the facility failed sugar results, so routine insuling clinical record for reviewed with publications blood sugar moderated (resident #48). The sugar resident #48 is to ensure residents reviewed with publications accurately documents.	naintain clinical records on accordance with accepted lards and practices that are ely documented; readily estematically organized. I must contain sufficient natify the resident; a record of essments; the plan of care ded; the results of any ening conducted by the est notes. I'd review and interview, and to ensure blood eliding scale insulin and was documented in the for 1 of 4 residents only ening and insulin. The facility also failed ent treatments were sumented for 1 of 8 wed for treatments in a Stage 2 Sample of	F0514	Resident #48 blood glucose assessed immediately and determined to have no negat impact. Resident #6 was assessed for treatments and changes were required. All resident clinical records wereviewed to determine if the documentation needs were rousine to ensure the need for assessment or changes in condition as it relates to documentation in the clinical records for treatments or blo glucaose monitoring.	no vere met	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
		155038	B. WING			08/26/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				1	HITE RIVER BOULEVARD		
PARK\/IF	EW NURSING CEN	TER		1	E, IN47303		
				L	L, 1147 303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION OF ACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION
PREFIX	`	ICY MUST BE PERCEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE			
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	34.				All treatment records and Blo		
					Glucose Monitoring was aud and inservice training was	itea	
	Findings includ	le:			provided to the nurses on		
					documentation requirements	for	
	1.) The clinical	record for Resident #6			these two issues.		
	1 ′	on 8/25/11 at 8:45 a.m			Audits will be completed dail	y to	
					determine any deficient prac	tice	
	Resident #6's	current diagnoses			in the documentation for		
		vere not limited to			monitoring of blood glucose	or	
		peripheral vascular			treatments. This will be monitored by the Don or		
		•			designee. Recommendation	s will	
	disease, seizure disorder, iron deficiency, Parkinson's bronchitis and				be made to the QA committe		
					ensure blood glucose monito		
	neuropathy.				system is in place.		
					Unit Managers will		
	During an inter	view with Resident #6			complete MAR/TAT aud	its	
	on 8/23/11 at 8	::56 a.m., she indicated			to ensure		
	her arms hurt h	ner all the time. The			Blood sugar results, slid	lina	
	Resident indica	ated the nurses "rub			scale insulin and routine	- 1	
	cream on them	and it really helps."			insulin		
		dicated she had been			Is documented daily tim		
	without the cre	am for "18 days." She			two weeks, then three ti		
		ream was in a yellow			a week for four weeks a		
	tube.	iodiii wao iii a yonon				-	
	A Quarterly Minimum Data Set				then weekly for two mor	าเกร	
					and then monthly.		
	1				DON/or designee will	ا ا	
	Assessment, dated 6/10/11, indicated the resident was independent with cognitive ability and could make her own decisions. Resident #6 was on a list of residents who were interviewable that was provided by the				review MAR/TAR weekl	y for	
					three		
					months to ensure blood		
					sugar results, sliding sca	ale	
					insulin		
					and rountin insulin is		
	Administrator of	on 8/22/11 at 12:00			documented.		
	noon.				Identified trends will be		
					reviewed in QAA month	_{lv}	
	Resident #6 ha	ad a healthcare plan,			. Stietted in Withinitia	· ,	

ll '	R/SUPPLIER/CLIA	(X2) MU	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICAT	IDENTIFICATION NUMBER:		. BUILDING 00		COMPLETED		
155038		B. WING			08/26/20	011	
<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF PROVIDER OR SUPPLIER			l	HITE RIVER BOULEVARD			
PARKVIEW NURSING CENTER			l	E, IN47303			
(X4) ID SUMMARY STATEMENT OF	DEFICIENCIES		ID			(X5)	
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG REGULATORY OR LSC IDENTIFY			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
dated 6/6/11, which indic	·			x 3 months and quarter	lv 1		
resident had a problem li				thereafter to	',		
alteration in comfort relat				determine further educa	ation		
secondary to generalized	•			and/or further			
Interventions for this prol				monitoring needs. Ident	ified		
included, administer pain				non-compliance			
as ordered, monitor and				will result in one to one			
effectiveness of medicati				re-education up to			
	•			•	, l		
for verbal and non-verba symptoms of distress or	_			and including termination	лı.		
1 , .	Paill			Any identified	,		
unrelieved by ordered				trends will be presented	¹		
treatments/medications.				and reviewed			
Desident #01	A mala cadada d			during QAA tio detiermine furtihe educational needs.	er		
Resident #6 had a currer	• •			Completion Date 9-26-2011			
order for Aspercream 10				2011p1011011 Date 0 20 20 11			
apply topically 3 times a	•						
needed. The original date	e of the						
order was 6/30/11.							
	_						
During observation and in							
Nursing Staff #1 on 8/25							
a.m., she indicated Resid							
have an order for Asperc	ream, three						
times daily. The Aspercre	eam						
treatment was in a yellow	tube. She						
indicated the cream shou	ıld be applied						
by nursing and documen	* *						
was applied. Nursing Sta	aff #1 went to						
the treatment cart and Re							
had an empty tube of As	had an empty tube of Aspercream						
topical treatment in the c							
	Aspercream was labeled as having						
been received from the p							
7/31/11. The nurse indic	•						
not aware the medication							
FORM CMS-2567(02-99) Previous Versions Obsolete		BLS311	Facility I	D: 000013 If continuation s	heet Doc	ge 55 of 58	

AND PLAN OF CORRECTION IDEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	i i	e survey pleted /2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET 2200 \	ADDRESS, CITY, STATE, ZIP OWNITE RIVER BOULEV.		
	SUMMARY S (EACH DEFICIEN REGULATORY OR and she would The July and A sheet for Resid documentation having been ap the months of J treatment shee Aspercream 10 topically 3 time The treatment shee treatment shee treatment had a nursing initials treatment had a nursing staff, ex Aspercream wa 2.) The clinical #48 was review a.m. Resident #48's included, but w diabetes mellitu	TER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) re-order. ugust 2011 treatment ent #6 lacked of any Aspercream plied at any time for luly and August. The t had the listed as 1 % cream apply s a day as needed. Sheets were blank. No were present on the ts to indicate the administered by ven though the tube of	2200 \	WHITE RIVER BOULEV	ORRECTION SHOULD BE	(X5) COMPLETION DATE
	for the following	ad physician's orders g, od glucose levels				
	before meals a a.m., 11:00 a.m	nd at bedtime. 7:00 a., 4:00 p.m. and 8:00 all date of this order				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155038			A. BUIL	DING	NSTRUCTION 00	ľ	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE HITE RIVER BOULEVARD E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	insulin coverag	Novolog sliding scale e based on blood according to the scale					
	200 - 250 = 2 u 251 - 300 = 4 u 301 - 350 = 6 u 351 - 400 = 8 u less than 70 or the physician.	nits nits					
	C. Administer Novolog 15 units before lunch.						
	Review of the June Medication Administration Record (MAR) for Resident #48 lacked documentation of any blood glucose results on June 12, at 4 p.m., and June 24, at 4 p.m.						
	#48 lacked doc	lune MAR for Resident umentation of Novolog given before lunch on 4, 27, and 30.					
	of Nursing on 8 additional informal related to the later results and Novellunch document and times noted	view with the Director /25/11 at 3:45 p.m., mation was requested ack of blood sugar volog 15 units before tation on the dates d above.					

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		155038	A. BUILDING	00	08/26/2011
		10000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF P	PROVIDER OR SUPPLIER		l l	/HITE RIVER BOULEVARD	
	W NURSING CEN		MUNCI	E, IN47303	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		RN Consultant	IAG		DAIL
	indicated	TAN Consultant			
		e any additional			
		provide related to the			
	-	ation for blood sugar			
		5 units of Novolog			
		pefore lunch for the			
	dates and times	s noted above.			
	0.4.50(.)(4)				
	3.1-50(a)(1)				
	3.1-50(a)(2)				